What can palliative care learn from the Covid-19 pandemic?

Across the globe 2020 has been a year where all health systems have experienced huge pressures to meet the demands of a pandemic unprecedented in both scale and impact. It has forced us to confront the fragility of assumptions about human health, as well as the risks associated with poverty, ethnicity and age. The disruption to services, including palliative care, have never been on such a large scale and suggests a need to capture what we can from a situation that would never be replicated other than in a similar emergency.

For the majority of our patients who are supported in the community, all of whom are facing a life limiting illness or the end of life, meeting their needs became a challenge that demanded innovation. Whilst we knew of people who still had to be seen due to ongoing symptom management needs, or whose families required advice about appropriate end of life care, visits to people's homes, or to care homes, suddenly had the added obstacle of wearing essential personal protective equipment (PPE). For many working in palliative care this new barrier acted as a powerful reminder of our own vulnerability, but also of those that we continued to care for.

Since the emergence of Covid-19 our personal and professional lives have changed beyond belief. At St Christopher's Hospice in London we have seen colleagues become sick, and unable to work due to the virus although, thankfully, no-one has been hospitalised. At the same time, significant numbers of our team have been forced to self-isolate or to shield due to pre-existing long-term health conditions. A number of colleagues live alone, and their sense of isolation suddenly became palpable, both when in work, and more especially when they were required to work from home alone. The need to show compassion to one another has never been greater.

Many of us have enjoyed seeing our 'working from home team' on twice-daily virtual meetings and have witnessed colleagues rise to new challenges presented daily. Also appreciated has been the sense of love, humour and courage that helped everyone get through each day. We have worried about each another. When going into a patient's room, home or care home, we have been aware of the risks of putting ourselves and our patients at risk of Covid-19. In addition, when going home to our families, partners and friends we have had an acute awareness of needing to protect them too.

Online communication, including clinical consultations, have increased during the Covid-19 crisis and have become an obvious and efficient way to connect with our patients, families, carers and care home staff. Not only for our care staff, but also for our allied health care professionals who quickly adapted their approach to rehabilitative palliative care, in running on-line rehabilitation sessions, and providing complementary therapy. A practice that may have been debated for years about whether and how it could be done was established overnight and has quickly become routine for assessing patients in urgent need. Whilst initially presented as a way forward for continuing to support patients, after three months we are still learning that whilst benefits exist with such technology, the loss of a 'hands on' approach for assessing and caring for people in their homes does not necessarily allow us to see the whole person, or indeed the whole picture. We are now evaluating this approach to our future practice and exploring whether a blend of approaches might be more appropriate.

Inevitably there have also been a number of distressing situations. We have taken calls for advice and reassurance from isolated people, including general practitioners, care home colleagues and

paramedics, to name but a few. As such St Christopher's Hospice was seen as a virtual support centre for the wider community and they called on us all to react in humane and responsive ways. We developed a suite of online resources to support healthcare professionals with everything from verifying a death to having challenging conversations with families. Our Education Team also developed a series of online learning sessions for staff working at NHS organisations, care homes, general practice and many more. Looking back, this time also served to remind us of the need to innovate, both as individual practitioners but also as an organisation.

As a result of Covid-19 hospice staff have also been required to develop new skills, or to draw on skills that they may have been qualified for but may not always have used much before. One example is the increased levels of remote prescribing carried out by non-medical prescribers. In a time of crisis, and even with appropriate policies and procedures to protect practitioners and patients, it was clear that prescribing could be a source of anxiety for some colleagues when the working context was already characterised by so much stress and anxiety (RCN 2020, weblink).

Similarly, changes around verification of death in the UK, and resultant changes to the policy and practice of nurse verification of Adult Expected Deaths in the community (Hospice UK 2020), has impacted on the work of individual nurses. Excellent examples were witnessed of nurses doing all they could to support carers and family members immediately following a patient's death, at a time when those who would normally verify death had less time to carry it out.

Further changes to practice included teaching carers to give injections to manage particular symptoms, such as pain or nausea. From such clinical innovation it was possible to see immediate benefits and appreciate how helpful new skills were in this situation, but we were also aware of the potential risks associated with aspects of care being carried out in this way. Patient safety was a constant theme at such times.

We are certainly now in a new world, and with the insights gained from each of us during this crisis, we know that things will never be the same again. Much has been confirmed about the inherent value of teamwork and trusting in our abilities whilst maintaining a close eye on the provision of safe and humane palliative care.

On reflection we have also learned that some aspects of hospice care provision may have become institutionalised and practices have been driven by routine rather than need. The changes brought about by Covid-19 have certainly been disruptive but have also taught us to remain to open to creativity and innovation in order to ensure that the best of palliative care is available to all (Woolliscroft 2020).

The purpose of palliative care was clarified sharply on our TV screens as so many were seen to have succumbed to this virus, yet many died also alone without loved ones close to them. Reflecting on the role of the hospice sector during the Covid-19 pandemic it can be seen that society still has much to learn about planning for better dying as part of life and we now know that hospices and palliative care services still have much to teach.

From the experience at St Christopher's many echoes of thanks are sent out to all nurses, and all our colleagues in other health care professions. We hope that all nurses, and the wider palliative care team, feel a sense of pride for everything they have done, in whatever country, role or care setting,

during the Covid-19 pandemic of 2020. The learning from this crisis will be both personal and professional, but the lessons for palliative care services could be transformative.

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